U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 24 August 2005

Case No. 2004-BLA-5890

In the Matter of

JOSEPH E. KOLICK
Claimant,

v.

GATEWAY COAL COMPANY
Employer,

and

INTERNATIONAL BUSINESS AND
MERCANTILE REASSURANCE COMPANY
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Cheryl Cowen, Esq.
For the Claimant

Christopher A. Wildfire, Esq.
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER—AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the Act). DX 1. The Act and implementing regulations, found in Title 20 of the Code of Federal Regulations (Regulations), provide compensation and other benefits to

coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis or CWP) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

PROCEDURAL HISTORY

Claimant filed this claim for benefits with the Department of Labor (DOL) on September 19, 2002. DX 2. The District Director issued a Proposed Decision and Order awarding Benefits on November 17, 2003. DX 30. On December 4, 2003, Employer requested a formal hearing before an ALJ. DX 32.

On December 7, 2004, I held a hearing in Pittsburgh, Pennsylvania. The Claimant and the Employer were represented by counsel, and I admitted Director's exhibits 1–40 and Claimant's Exhibits 1–5 into evidence. TR 5, 16, 17. After reviewing Claimant's exhibits, I found that Claimant's counsel had mischaracterized the x-ray evidence at the hearing and had, in fact, submitted three x-ray interpretations for Claimant's case in chief. As this is contrary to § 725.414, I will now exclude CX 3, Dr. Ahmed's interpretation of the April 3, 2003 x-ray. I also note that CX 4, the medical report of Dr. Garson, contains an x-ray reading that further exceeds the evidentiary limitations. I will consider Dr. Garson's report except for that part of the report that discusses the x-ray evidence. I failed to admit any of the Employer's exhibits at the hearing. Having reviewed the seven exhibits submitted by the employer, I find that they all comply with § 725.414. Consequently, EX 1–7 are hereby admitted into the record. The record is now closed.

At the hearing, the parties stipulated to forty-one years of coal mine employment; Gateway Coal Company's status as the responsible operation; one dependent, namely the Claimant's wife, Ann; and that Mr. Kolick is totally disabled by a pulmonary disease. TR 18–19. Having reviewed the record, I accept these stipulations. DX 5; TR 25. The following issues remain to be decided:

ISSUES

(1) Whether the miner has pneumoconiosis;
(2) Whether the miner's pneumoconiosis arose out of his coal mine employment; and
(3) Whether the miner's disability is due to pneumoconiosis.

TR 18–19.

FINDINGS OF FACT

Date of Filing

Claimant filed his current claim on September 19, 2002. DX 2. I find that Claimant timely filed the present claim pursuant to 20 C.F.R § 725.308.

Responsible Operator

The Employer concedes that it is the last employer for whom the Claimant worked a cumulative period of at least one year. Consequently, I find that Employer is the properly designated responsible coal mine operator in this case.

Dependents

I find that Claimant has one dependent for purposes of augmentation of benefits under the Act: his wife, Ann. DX 2; TR 18.

Personal, Employment and Smoking History

The Claimant was born on December 12, 1925, and was seventy-eight years old at the time of the hearing. TR 19; DX 11. He lives with his wife, Ann, whom he married May 2, 1953. TR 20; DX 10. Claimant testified that he began experiencing increased shortness of breath before he applied for the job of lamp man. TR 22. This problem has become worse since ending his employment, so that when he walks any distance he has to stop to rest. TR 22. Mr. Kolick uses oxygen or an inhaler to relieve his shortness of breath. Drs. Cohen and Weaver of the Centerville Clinic prescribed the oxygen. Claimant uses oxygen all night and as needed during the day. The oxygen has allowed him to sleep through the night, and he also uses Albuterol and Combivent inhalers as well as a nebulizer. TR 22–23. He regularly treats at Centerville Clinic for his pulmonary problems. TR 25. His family physician is Dr. Chao. TR 26. Mr. Kolick testified that he also suffers from arthritis and high blood pressure. TR 23.

Claimant stated that he smoked from the age of thirty until 1997 when he was seventy-two years old, resulting in a smoking history of forty-two years at an average rate of one pack per day. TR 24–25. Sometimes he smoked more than a pack of cigarettes a day but he also smoked less than that while working. TR 24.

Claimant's last coal mine employment was in 1988 with Gateway Coal Company as a lamp man. TR 20, 25. His duties included cleaning and repairing lamps, cleaning bathrooms, and retrieving supplies from storage for the next shift. TR 20. The job required him to carry items weighing between five and twenty pounds. TR 20. Mr. Kolick worked in this capacity for four years. All his previous mining work was underground, and most of that was at the face. TR 20–21.

Medical Evidence

Chest X-Rays

Exh. #	X-ray Date	Physician/Qualifications	Interpretation
CX 1	4/3/03	Cappiello/BCR, B	1/1; s/p; 6 zones; emphysema
EX 3	4/3/03	Wolfe/BCR, B	0/0; bullous emphysema
DX 13	4/3/03	Navani/BCR, B	Quality 3
DX 13	4/3/03	Jaworski/B	1/0; s/t; 3 left zones; emphysema
EX 1	8/5/03	Renn/B	0/0; emphysema
CX 2	5/4/04	Cohen/B	1/0; p/s; 6 zones; emphysema
EX 6	5/4/04	Shipley/BCR, B	Negative; emphysema
EX 2	5/18/04	Goodman/B	Negative; emphysema

Pulmonary Function Studies[1]

Exh.#	Date	Age/ Height	FEV1	MVV	FVC	Qualify?	Impression
DX 13	4/3/03	77/66”	1.09	---	2.40	Yes	Mild restriction and severe obstruction; found acceptable by Dr. Fiwova. DX 13.
CX 4	12/29/03	78/66”	1.27 1.23*	--- ---	2.64 2.44	Yes Yes	Moderate obstructive lung defect
CX 2	5/4/04	78/66”	1.11 1.12*	56 ---	3.14 3.26	Yes Yes	Severe obstructive defect; hyperinflation and severe diffusion impairment consistent with emphysema
EX 2	5/18/04	78/67”	1.23 1.11*	42 50*	3.20 2.68*	Yes Yes	Severe obstructive impairment but effort was variable due to coughing and fatigue

[1] An asterisk (*) indicates a post-bronchodilator value. A “qualifying” pulmonary study or arterial blood gas study yields values equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

Arterial Blood Gas Studies

Exh.#	Date	pCO2	pO2	Qualify?	Impression
DX 13	4/3/03	30	63	Yes	pO2 reduced in relation to patient's age
EX 1	6/11/03	43	66	No	
EX 2	5/18/04	33	70	No	Mild hypoxemia

Physicians' Reports

On April 3, 2003, **Dr. Andrzej J. Jaworski**, examined the Claimant at the request of the Department of Labor. DX 13. He noted 42.5 years of coal mine employment, including thirty-eight underground and the last 4.5 as a lamp man requiring him to clean lamps, sweep, and collecting supplies weighing twenty pounds. The physician also considered a history of smoking one pack of cigarettes a day for forty-two years before quitting in 1997. During the examination, Dr. Jaworski conducted an x-ray, a blood gas study, a pulmonary function study, and an EKG. He considered the x-ray positive for pneumoconiosis, while the pulmonary function study exhibited a mild restriction and a severe obstruction, the blood gas study revealed a reduced PO2, and the EKG showed a regular sinus rhythm. Dr. Jaworski also considered a medical history of wheezing, arthritis, prostate cancer, and high blood pressure. Mr. Kolick complained of a productive cough, wheezing, shortness of breath, chest pain, and ankle edema. Physical examination showed moderately decreased breath sounds bilaterally, prolongation of the expiratory phase, and scattered expiratory wheezes.

Based on his examination, Dr. Jaworski diagnosed a severe obstructive airway disease due to cigarette smoking with significant contribution from coal dust exposure; mild restrictive pattern most likely due to air trapping related to COPD; increased interstitial markings in the right lung compared to the left lung based on the chest x-ray of uncertain etiology; chest pain possibly due to angina; and uncontrolled hypertension probably due to essential hypertension. He added that the "mildly increased interstitial pattern in the right lung is not, however, consistent with coal worker's [sic] pneumoconiosis as the small opacities are irregular. The paucity of bronchovascular markings in the left lung raises the possibility of unilateral left sided endobronchial obstruction with check valve mechanism." In Dr. Jaworski's opinion, the miner is totally disabled predominantly because of his severe obstructive airway disease due to cigarette smoking and coal dust exposure.

Dr. Jaworski was deposed on November 4, 2004 and provided his credentials. He is board certified in internal medicine, pulmonary disease, and critical care medicine. He testified that the x-ray he considered showed small irregular opacities that, at the time, he felt were not consistent with pneumoconiosis. However, he testified that recent literature supported the conclusion that these opacities are consistent with pneumoconiosis. Dr. Jaworski stated that the opacities' being only on the left side was not consistent with pneumoconiosis unless there was unilateral asymmetrical emphysema or air trapping, which makes it appear that way. He stated that he would disagree with Dr. Cohen's finding of rounded opacities in six zones. Dr. Jaworski made clear that he did diagnose pneumoconiosis and stated that studies show that the

development of obstructive airway disease due to chronic exposure to coal dust is very similar to that caused by cigarette smoking. The miner's years of exposure to coal dust further assisted him in making the diagnosis.

Dr. Jaworski opined that the miner's severe obstructive airways disease is due to both cigarette smoking and coal dust exposure. He also found a mild restrictive pattern on spirometry that he felt was most likely secondary to chronic obstructive lung disease but he could not be sure without considering lung volumes. He opined that pneumoconiosis is a significant factor in the miner's pulmonary disability. He allowed that Mr. Kolick's smoking history was sufficient to cause the degree of disability he suffers but Dr. Jaworski stressed that he had to also consider the miner's other exposures. Dr. Jaworski testified that bullous emphysema is the destruction of lung tissue that cannot be regenerated and he opined that coal dust exposure has a similar effect to the remodeling of the airways caused by smoking.

Dr. Joseph J. Renn, III, examined the Claimant at the request of the Employer on August 5, 2003. EX 1. He considered forty-two years of coal mine employment, lastly as a lamp man but also as a hand loader, general inside laborer, continuous miner operator, shuttle car operator, inside mechanic, long wall mechanic, and belt mechanic. Mr. Kolick indicated that he had smoked one pack of cigarettes a day for fifty years, quitting in 1993. The miner complained of shortness of breath with exertion, a daily nocturnal productive cough for five years, and wheezing. The miner's medical history was significant for atherosclerotic coronary vascular disease, angina pectoris, chronic bronchitis, and prostate cancer. Dr. Renn considered the results of an x-ray that was read as negative. Neither a pulmonary function study nor a blood gas study could be conducted due to high blood pressure. Physical examination revealed clear lungs with the exception of a hyper resonant percussion note. Dr. Renn also reviewed office records from Centerville Clinics from 1983 through 2003, hospital records from January 2000 and October 2001, Dr. Jaworski's report, ten EKG reports, six pulmonary function studies from April 1998 to April 2003, the April 3, 2003 blood gas studies, eleven x-ray interpretations from April 1998 through April 2003, and a myocardial perfusion stress test interpretation.

Dr. Renn diagnosed chronic bronchitis due to smoking; pulmonary emphysema due to smoking; old pulmonary granulomatous disease; moderately severe to severe obstructive ventilatory defect due to the bronchitis and emphysema; hypertension; atherosclerotic coronary vascular disease; and atherosclerotic peripheral vascular disease. He found no evidence of pneumoconiosis. He opined that none of the diagnosed conditions was caused by or contributed to by coal mine dust exposure. He related the bronchitis and emphysema with obstructive ventilatory defect to years of smoking. Dr. Renn declared Mr. Kolick totally disabled from working as a coal miner.

Dr. Renn was deposed on November 4, 2004. EX 5. Dr. Renn is board certified in internal medicine, pulmonary diseases, and forensic medicine. He reviewed the results of his examination of Claimant, explaining that the miner's hyper resonant percussion, wheezing, and chronic productive cough on physical examination are consistent with emphysema and asthma but not pneumoconiosis, and the x-ray finding of emphysema was not the type seen in pneumoconiosis; rather it was bullous emphysema consistent with tobacco-smoke induced emphysema. He further explained that the lung volume studies showed hyperinflation and air

trapping with normal total lung capacity that pointed to emphysema and not pneumoconiosis. Finally, the diffusion capacity studies revealed marked impairment consistent with tobacco-smoke induced emphysema but not pneumoconiosis. Dr. Renn testified that the 1998 PFT showed reversibility, thus pointing away from pneumoconiosis, and that the later tests did not reveal bronchoreversibility because of remodeling of the lungs caused by the inflammatory reaction of emphysema. Regarding disability, Dr. Renn opined that the cause of the Claimant's respiratory impairment is tobacco smoking. He testified that Mr. Kolick's coal mine dust exposure has not caused an adverse effect on the formation of his pulmonary symptoms or his airways disease.

On January 22, 2004, **Dr. Warfield Garson** of the Centerville Clinic examined the Claimant. CX 4. Dr. Garson noted that Mr. Kolick's work history had not changed. He was aware of that history based on past examinations. DX 16. He noted that the miner did not currently smoke or use tobacco. Symptoms included a productive cough, wheezing, shortness of breath with any exertion, ankle edema, and occasional chest pain. Physical examination showed clear lungs, and the miner's medical history was significant for emphysema, chronic bronchitis, and asthma. During the examination, Dr. Garson conducted an x-ray[2] and a pulmonary function study. The pulmonary function study showed a moderate obstructive lung defect with an insignificant response to bronchodilation. Dr. Garson diagnosed suspicious coal workers' pneumoconiosis; chronic obstructive pulmonary disease; hypertension; benign prostatic hypertrophy; bronchitis; and arthritis. He did not provide any opinion regarding disability, and it is unclear to what extent the diagnosis of suspicious pneumoconiosis is based on the x-ray interpretation. Dr. Garson is board certified in preventive medicine.

Dr. Garson was deposed on September 16, 2004. EX 4. He testified that he first saw the Claimant on March 3, 1988 and did not see him again until his January 2004 examination. He reviewed the reports of Drs. Renn, Goodman, Cohen, and Jaworski. He testified that he diagnosed legal pneumoconiosis based on the miner's complaints, physical findings, work and medical histories, and the results of the spirometry and x-rays. He would make that diagnosis even if the majority of x-ray evidence were negative, and in spite of the miner's smoking history, because of the other symptoms of chronic pulmonary disease, air trapping, and COPD. Dr. Garson testified that Mr. Kolick is totally disabled and that pneumoconiosis is a substantial factor in causing that disability, while he recognized the clear relationship of the cigarette smoking to the disability, as well. Dr. Cohen also believes that the miner has centrilobular emphysema that is probably caused by coal dust exposure. He acknowledged on cross examination that the miner's smoking history was sufficient to cause Mr. Kolick's symptoms of a productive cough, bronchitis, shortness of breath, and wheezing, as well as his emphysema and hypoxemia. He felt it was possible that the cigarette smoking history could be sufficient to cause the miner's disabling impairment.

Dr. Robert A. C. Cohen examined the miner on May 4, 2004. CX 2. Dr. Cohen noted that Mr. Kolick had worked forty-two years in the coal mines at various jobs including as a hand loader, shuttle car driver, cutting machine operator, continuous miner operator, section mechanic,

[2] Because Dr. Garson's x-ray would constitute Claimant's third affirmative x-ray reading, and, thus, violate § 725.414, it cannot be considered. Consequently, any part of Dr. Garson's opinion that relies upon that x-ray evidence will also not be considered.

long wall operator, belt mechanic, and lamp man and that he had smoked one pack of cigarettes a day for fifty years before quitting in 1998. During the examination, Dr. Cohen conducted an x-ray and a pulmonary function study. The pulmonary function study showed a severe obstructive defect with hyperinflation and severe diffusion impairment consistent with emphysema. The x-ray was read as category 1/0. Dr. Cohen also considered a medical history significant for hypertension and possibly bronchitis/emphysema. Mr. Kolick complained of shortness of breath, a productive cough, and chest pain. Physical examination showed poor air entry with decreased breath sounds in all lung fields bilaterally but no wheezing.

Dr. Cohen diagnosed coal workers' pneumoconiosis, essential hypertension, and peripheral vascular disease. His diagnosis of pneumoconiosis was based on the miner's work history with dust exposure, symptoms of lung disease such as a chronic productive cough and progressively worsening shortness of breath, the pulmonary function study that demonstrated a severe obstructive lung disease with diffusion impairment that he believes is secondary to coal dust exposure and tobacco smoke exposure, the blood gas study evidence of significant hypoxemia necessary to require home oxygen therapy, and the x-ray. In his opinion, the miner is totally disabled from a pulmonary standpoint. He stated:

> The sum of the medical evidence in conjunction with this patient's work history indicates that this patient's 40 years of coal dust exposure and his 50 pack year exposure to tobacco smoke was significantly contributory to the development of his severe obstructive lung disease, severe diffusion impairment, and severe gas exchange abnormalities.

Dr. Cohen is board certified in internal medicine, pulmonary disease, and critical care medicine.

Dr. Cohen was deposed on December 13, 2004. CX 6. Dr. Cohen testified that it is well documented that pneumoconiosis can cause irregular opacities and opacities in the lower lobes but not the upper. He reiterated his conclusion that Mr. Kolick has a totally disabling severe obstructive lung disease caused by exposure to both coal mine dust for forty-nine years and smoking for 50–75 pack-years. His diagnosis would not change even if the x-ray evidence were found negative. He believes that the Claimant's forty years of coal mine dust exposure has significantly contributed to his total disability. Dr. Cohen testified that patients who are susceptible to developing emphysema from tobacco smoke are also sensitive to coal mine dust. He knows of no data to support the finding that pulmonary function study results point to a cause of disability. Dr. Cohen opined that coal mine dust can cause damage to the lungs that may not show up on x-ray yet would result in a diffusion impairment.

Employer engaged **Dr. George B. Goodman** to examine Mr. Kolick on May 18, 2004. EX 2. Dr. Goodman considered a medical history of high blood pressure and angioplasty. He noted symptoms of shortness of breath, wheezing, and a cough with sputum. Dr. Goodman considered a history of smoking one pack of cigarettes a day for forty years before quitting in the late 1990s, and forty-two years of coal mine employment, performing all the jobs listed above, lastly that of lamp man. Physical examination showed diminished breath sounds, mild prolongation of the expiratory phase of respiration, and a few crackles in the bases.
Dr. Goodman took into account the results of an x-ray, a pulmonary function study, and a blood

gas study. The x-ray was found negative. The pulmonary function study showed severe obstruction typical of emphysema. The blood gas study revealed mild hypoxemia. He also reviewed the Centerville Clinic records from 1988 to 2003, and the reports of Drs. Jaworski and Renn.

Dr. Goodman did not diagnose pneumoconiosis or any pneumoconiosis-based disability. He found a severe respiratory impairment and opined that Mr. Kolick is totally disabled due to his severe chronic obstructive pulmonary disease. His opinion is based on the x-ray, pulmonary function study, physical examination, and clinical history of progressive dyspnea, cough and sputum production. He felt that the impairment is most directly related to the miner's smoking history.

Dr. Goodman was deposed on December 17, 2004. EX 7. He is board certified in internal medicine, pulmonary disease, geriatric medicine, emergency medicine, and critical care medicine, and he is a B-reader. He reviewed the reports of Drs. Garson and Cohen, Dr. Garson's deposition, the Centerville Clinic records, and the x-ray readings of Drs. Cappiello and Ahmed. Dr. Goodman explained that in conjunction with his examination of the Claimant, the Claimant underwent pulmonary function testing with measurement of spirometry, lung volumes, and diffusion capacity, and Dr. Goodman found the data consistent with severe obstructive impairment and findings frequently seen in emphysema such as severe hyperinflation and air trapping. Both the total lung capacity and the residual volume were elevated, while there was a mild-to-moderate reduction in diffusion capacity. The physician explained that the reduction in the FEV1 and the FEV1-to-FVC ratio is indicative of an obstructive defect. Dr. Goodman testified that these results do not address the etiology of the obstruction. He further opined that it is possible to differentiate between the effects of smoking and coal mine dust exposure, namely that a pattern of obstructive impairment and the physical increase in anteroposterior diameter are not expected as a result of pneumoconiosis. He attributed the miner's respiratory impairment to his smoking because of a long history of heavy tobacco smoking, the abnormal physical symptoms, and objective findings discussed above. Regarding the lack of bronchodilator response in the later pulmonary function studies, Dr. Goodman felt it did not point to any specific etiology. He does not believe that coal dust remodels the airways the same way that smoking does and stated that there is literature on this issue that arrives at opposite conclusions. He agreed that coal dust exposure can cause a cough and sputum production but that it only causes shortness of breath when it is complicated pneumoconiosis.

Dr. Goodman testified that he did not diagnose pneumoconiosis because he felt the x-ray did not show it. He admitted that he could not completely rule out coal dust exposure as a cause of disability. Dr. Goodman testified on cross examination that he believes progressive massive fibrosis must be present in order for pneumoconiosis to be totally disabling. However, he also testified that if he had found the existence of pneumoconiosis by x-ray, he might have attributed some of the miner's pulmonary impairment to the disease.

Hospital Records and Medical Office Records

The Employer has sought to have considered treatment records from Centerville Clinic that date back to 1988. DX 16. According to § 725.414(a)(4), any record of a miner's medical

treatment for a respiratory or pulmonary or related disease may be received into evidence. To the extent these records are medically acceptable and address the Claimant's treatment for his pulmonary problems, I will consider them as "other medical evidence" under § 718.107.

There are several x-rays and pulmonary function studies that cannot be considered along with the x-ray and pulmonary function study evidence enumerated above. **Dr. Garson** examined Mr. Kolick on March 3, 1988. He considered complaints of a cough, wheeze, shortness of breath, and chest pain; a 37.5-year coal mine employment history; and a forty-three-pack-year smoking history that ended in February 1988. The miner's medical history was significant for hypertension. Physical examination was normal, displaying no dyspnea, wheezing, cyanosis, or cough. Dr. Garson also considered the results of an x-ray, an EKG, a blood gas study, and a pulmonary function study. The x-ray was considered negative for pneumoconiosis, the pulmonary function study showed a "normal obstructive defect," and the blood gas study demonstrated moderate hypoxia. Dr. Garson diagnosed arteriosclerosis with coronary heart disease and angina pectoris; hypertension; arthritis; degenerative thoracic spine; and minimal chronic obstructive pulmonary disease. He felt Mr. Kolick was totally disabled from his last job as a lamp man but added that it was primarily due to his arthritis, cardiac and orthopedic problems and not pneumoconiosis or his pulmonary problem.

CONCLUSIONS OF LAW

Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202–718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Existence of Pneumoconiosis

The Regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The Regulations' definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises

> those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal-mine employment. *Id.* A claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320.

The Regulations provide four methods for establishing the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)–(4). As there is no autopsy or biopsy evidence and Claimant is not eligible for the presumptions,[3] only chest x-rays, CT scans, and medical opinions can establish the existence of pneumoconiosis in his claim. In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

There are seven readings of four separate x-rays and one reading for quality purposes only. The April 3, 2003 x-ray was found to be a quality 3 film with overlying scapulae by reviewing board-certified radiologist Dr. Navani, who is also a B-reader. Dr. Jaworski, a B-reader, found the film positive for pneumoconiosis with a category 1/0 reading. He felt the film was quality 2 and, like Dr. Navani, indicated there were overlying scapulae. Dr. Cappiello, a dually certified reader, also felt the x-ray was positive and made a category 1/1 reading, while Dr. Wolfe, another dually certified reader, felt the film was negative for pneumoconiosis but showed bullous emphysema. Dr. Cappiello found the film to be quality 2, and Dr. Wolfe felt it was a quality 1 x-ray. I rely on the readings of the three best qualified interpreters, Drs. Navani, Cappiello, and Wolfe. *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984). Of the two of these physicians who provided interpretations, Dr. Cappiello, who found the film positive, felt it was of worse quality than Dr. Wolfe, who found the x-ray negative. I defer to the reading of the radiologist who felt the x-ray was of better quality. Therefore, I consider this film negative.

Mr. Kolick's August 5, 2003 x-ray was found negative by Dr. Renn, a B-reader, and it was not reread. Therefore, I find it negative.

The May 4, 2004 x-ray was found positive by Dr. Cohen, a B-reader. He found category 1/0 pneumoconiosis. This film was reread by Dr. Shipley, who felt the film was negative for pneumoconiosis but revealed emphysema. Dr. Cohen found the film to be quality 2, and Dr.

[3] Claimant is ineligible for the § 718.304 presumption because he has not been diagnosed with complicated pneumoconiosis. Claimant cannot qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant is ineligible for the § 718.306 presumption because he is still living.

Shipley felt it was a quality 3 film due to overexposure. In this case, I defer to the superior credentials of Dr. Shipley and consider this x-ray negative.

The final x-ray of record, dated May 18, 2004, was found negative by Dr. Goodman, a B-reader. It was not reread. Therefore, I consider it negative.

In summary, there are three positive readings and four negative readings. The four negative readings are by two B-readers and two physicians who are both B-readers and board-certified radiologists. The three positive readings are by two B-readers and one dually certified reader. I defer to the superior credentials of Drs. Cappiello, Wolfe, and Shipley, and based on the above analysis, I conclude that Claimant has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Additionally, a determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a). Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 BLR 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report to be not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 BLR 1-1130 (1984). A medical opinion is not sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 BLR 1-368 (1983).

Drs. Jaworski, Garson, and Cohen diagnosed pneumoconiosis or its equivalent, while Drs. Renn and Goodman did not.

Dr. Jaworski's opinion is troublesome. He clearly diagnosed obstructive airway disease due, in significant part, to coal dust exposure, and this meets the definition of legal pneumoconiosis. However, he felt that the x-ray he read was not consistent with coal workers' pneumoconiosis because of the irregular shape of the opacities, despite his marking the film category 1/0 disease. At his deposition, Dr. Jaworski testified that he had recently come across medical literature to support the conclusion that pneumoconiosis can evince irregular opacities. This statement is confirmed by Dr. Cohen's deposition testimony. Still, he acknowledged that the pattern of unilateral opacities was inconsistent with pneumoconiosis absent asymmetrical emphysema or air trapping. Having considered Dr. Jaworski's opinion in its totality, I conclude that it supports a finding of pneumoconiosis. His opinion is well documented and adequately reasoned based upon his statement that if the miner has asymmetrical emphysema or air trapping, the x-ray is consistent with pneumoconiosis. Dr. Jaworski also maintains excellent credentials in the area of pulmonary medicine. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). Accordingly, I place some weight on his opinion.

Dr. Garson opined that Mr. Kolick has legal pneumoconiosis. In his January 2004 report, he was only "suspicious" of pneumoconiosis, and he diagnosed COPD. At his deposition, he stated that he did make the diagnosis of legal pneumoconiosis based on his belief that the COPD

is related to coal mine dust. I find his report well reasoned and documented. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). In comparing Dr. Garson's 1988 examination with the 2004 exam report, it is clear that he had accurate accounts of Claimant's coal mining and smoking histories. I also find that Dr. Garson's diagnosis is not primarily reliant on his x-ray reading, which is not admissible here. He clearly stated that the combination of the miner's symptoms, chronic pulmonary disease, and air trapping led him to his determination even if the x-rays were found to be negative. Accordingly, I place some weight on his opinion.

I find Dr. Cohen's opinion to be well documented and reasoned. Dr. Cohen's conclusion is based on his thorough examination of the Claimant. He explained that Mr. Kolick's symptoms are consistent with pneumoconiosis. Dr. Cohen also explained why the negative x-ray readings did not prevent him from making his diagnosis. Furthermore, Dr. Cohen's board certification in internal medicine, pulmonary disease, and critical care medicine merits great weight. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). For the foregoing reasons, I place great weight on his opinion.

Dr. Renn's opinion is well documented and reasoned. It is supported by the overall x-ray evidence, including readings by better qualified interpreters. His opinion is further bolstered by his clinical finding of clear lungs. He explained that the miner's type of emphysema—bullous—is not caused by coal mine dust but is consistent with that caused by tobacco smoke. Dr. Renn also based his conclusions on a review of the other medical evidence of record, thus providing him with a broader base of data on which to rely. Lastly, Dr. Renn also maintains excellent credentials in the area of pulmonary medicine. Consequently, I place some weight on Dr. Renn's opinion.

Dr. Goodman's opinion is well documented and he reviewed most of the medical evidence of record in making his decision. His finding is supported by the overall x-ray evidence, and he maintains impressive credentials. However, one of the reasons Dr. Goodman did not diagnose pneumoconiosis was because of the obstructive impairment exhibited by the pulmonary function studies. He stated that such a pattern is not expected as a result of pneumoconiosis, yet the Act recognizes that pneumoconiosis can cause an obstructive impairment. 20 C.F.R § 718.201 (2001). I find Dr. Goodman's opinion to be contrary to the Act because the other physicians recognized that pneumoconiosis can cause an obstructive impairment. *Blakley v. Amax Coal Co.*, 54 F.3d 1313 (7th Cir. 2001). Moreover, Dr. Goodman testified that he did not diagnose pneumoconiosis because he felt the x-ray he obtained was negative for the disease. I find that a physician's statement that he would not diagnose pneumoconiosis in the absence of a positive x-ray interpretation is hostile to the Act. *See Black Diamond Coal Co. v. BRB [Raines]*, 758 F.2d 1532 (11th Cir. 1985). Finally, Dr. Goodman admitted that the miner's symptoms of a cough and sputum production can be caused by coal dust exposure, thereby undermining one of the reasons why he did not diagnose the disease. For these reasons, I discount Dr. Goodman's opinion.

Based on all the evidence under § 718.202(a)(4), I find that the opinions of Drs. Cohen and Garson, as supported by Dr. Jaworski's, outweigh the opinions of Drs. Renn and Goodman. Therefore, I find that the medical opinion evidence establishes the existence of pneumoconiosis by a preponderance of the evidence. I find the medical opinion evidence more persuasive than

the x-ray evidence alone because it is based upon more than one single objective test. Therefore, I find that Mr. Kolick has established the existence of pneumoconiosis pursuant to § 718.202(a).

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten yeas or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with forty-one years of coal mine employment, is entitled to the rebuttable presumption at § 718.203. Employer has failed to rebut that presumption.

Total Disability

The Claimant must also show that his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the ALJ must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, then the ALJ must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on recon. en banc*, 9 B.L.R. 1-236 (1987).

The Employer has not contested that Mr. Kolick is totally disabled. This concession is supported by the four pulmonary function studies and April 3, 2003 blood gas study, all of which produced qualifying results under §§ 718.204(b)(2)(i) and (ii), respectively. In addition, every examining physician declared Claimant totally disabled. Accordingly, I find that Mr. Kolick suffers from a totally disabling respiratory impairment.

Total Disabilty Causation

The final element that Claimant must prove is that his total disability is caused by his coal-dust-induced disease. The regulations at 20 C.F.R. §718.204(c) (2001) contain a standard for determining whether total disability is caused by the miner's pneumoconiosis:

> A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in Sec. 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a 'substantially contributing cause" of the miner's disability if it: (i) Has a material adverse effect on the miner's respiratory or pulmonary

> condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.[P]roof that the miner suffers or suffered from a totally disabling respiratory or pulmonary impairment . . . shall not, by itself, be sufficient to establish that the miner's impairment is or was due to pneumoconiosis. [T]he cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report.

20 C.F.R. §718.204(c) (2001) (emphasis added). In *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit interpreted the "materially worsens" standard at 20 C.F.R. §718.204(c). Under the facts of the case, Employer argued that the miner's chronic obstructive pulmonary disease "was primarily, if not entirely, a consequence of the estimated quarter-of-a-million cigarettes he had smoked." The court found that, under the amended regulatory provisions, the mere fact that Claimant's non-coal dust related respiratory disease would have left him totally disabled even without exposure to coal dust, this would not preclude entitlement to benefits. The court held that Claimant "may nonetheless possess a compensable injury if his pneumoconiosis 'materially worsens' this condition."

In this case, Dr. Jaworski attributed Claimant's disability to both cigarette smoking and coal dust exposure. I find logical Dr. Jaworski's reasoning that although smoking alone can cause the impairment from which Mr. Kolick suffers, he could not ignore the miner's significant coal dust exposure history in addressing the issue of causation. He further testified that both conditions act similarly in their destruction of lung tissue. Accordingly, I place great weight on his opinion.

Dr. Garson stated that the miner's pneumoconiosis was a substantial factor in causing his total disability. I place very little weight on Dr. Garson's opinion because he did not explain how he reached his conclusion, admitted that the miner's smoking alone might be sufficient to cause his disabling impairment, and did not attribute disability to pneumoconiosis at all when he examined Mr. Kolick in 1988, a time when his examination was not in contemplation of litigation.

Dr. Cohen attributed Claimant's disability to both coal dust exposure and smoking, relying in part on the severe gas exchange abnormality, the severe diffusion impairment, the severe obstructive lung disease, and the extent and duration of Mr. Kolick's coal dust exposure. I find Dr. Cohen's reasoning sound and place great weight on it.

Dr. Renn attributed none of the miner's disability to coal dust exposure; he felt that the disability was due to smoking. Dr. Renn relied on the diffusion capacity studies that revealed marked impairment. These are the same studies that Dr. Cohen felt supported his conclusion to the contrary. Dr. Renn also believed that the lack of bronchoreversibility on the later pulmonary function studies was due to remodeling of the lungs caused by emphysema due to smoking. This conflicts directly with Dr. Jaworski's opinion that smoking and coal mine dust damage lung tissue in similar ways. I find Dr. Renn's opinion is not as well reasoned as Dr. Jaworski's and Dr. Cohen's. I find that it unfairly downplays the extent of Mr. Kolick's coal mine dust exposure. I further note that his failure to find the existence of pneumoconiosis is another factor

that detracts from the credibility of Dr. Renn's opinion. *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). Consequently, I place less weight on Dr. Renn's opinion.

Dr. Goodman associated Mr. Kolick's disability with his cigarette smoking. I find his opinion on this matter to also be contrary to the Act. He testified that in order for pneumoconiosis to be totally disabling, it must be complicated pneumoconiosis. In *Thorn v. Itmann Coal Co.*, 3 F.3d 713 (4th Cir. 1995), the Fourth Circuit held that a physician's statement that simple pneumoconiosis does not cause total disability "as a rule" was hostile to the Act. Dr. Goodman testified that the miner's obstructive defect pointed to emphysema due to smoking as the cause because an obstructive impairment is "not expected" as a result of pneumoconiosis. He felt that the lack of bronchodilator response in later pulmonary function studies was not indicative of any etiology, whereas the other physicians either explained that it was consistent with the fixed disease of pneumoconiosis or was caused by remodeling of the lungs due to emphysema. While Dr. Goodman acknowledged that medical literature establishing that coal mine dust exposure causes remodeling of the airways similarly to smoking exists, he does not espouse that position. Despite all this, Dr. Goodman also admitted that he could not completely rule out coal dust exposure as a cause of disability and that had he diagnosed the disease he might have attributed some of the impairment to pneumoconiosis. Accordingly, I find that his failure to find pneumoconiosis weakens the credibility of his opinion. For these reasons, I discount Dr. Goodman's opinion.

Based on the foregoing analysis, I find the opinions of Drs. Jaworski and Cohen more credible than Dr. Renn's and especially Dr. Goodman's. Accordingly, I conclude that Mr. Kolick has established by a preponderance of the evidence that his pneumoconiosis is a substantially contributing cause of his disability inasmuch as he has proven that it has had a material adverse effect on his respiratory or pulmonary condition. As Claimant has established all elements of entitlement, I conclude that he has established entitlement to benefits under the Act.

Date of Onset

In a case such as this, in which the evidence does not establish the month of the onset of total disability, benefits are payable beginning with the month during which the claim was filed. 20 C.F.R. § 725.303(d). Claimant filed the instant claim on September 19, 2002.

Attorney's Fee

No award of attorney's fees for services to Claimant is made herein, as no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. Her attention is directed to §§ 725.365 and 725.366 of the Regulations. A service sheet showing service upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of JOSEPH E. KOLICK for black lung benefits under the Act is hereby GRANTED, and it is hereby ordered that the Responsible Operator, GATEWAY COAL COMPANY, shall pay to Claimant, JOSEPH E. KOLICK, all augmented benefits to which he is entitled under the Act, commencing September 1, 2002.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).